	•	·
1	KAMALA D. HARRIS	
2	Attorney General of California FRANK H. PACOE	·
3	Supervising Deputy Attorney General JUDITH J. LOACH	
4	Deputy Attorney General State Bar No. 162030	
5	455 Golden Gate Avenue, Suite 11000 San Francisco, CA 94102-7004	
6	Telephone: (415) 703-5604 Facsimile: (415) 703-5480	
7	E-mail: Judith.Loach@doj.ca.gov Attorneys for Complainant	
8	BEFORE THE	
9	BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS	
10	STATE OF CALIFORNIA	
11	In the Matter of the First Amended Accusation	Case No. 2013-653
12	Against:	
13	SOUSAN EHTESHAMI KHOSRAVI aka SOUSAN SOUSAN EHTESHAMI	FIRST AMENDED ACCUSATION
14	KHOSRAVI aka MAHNAZ EHTESHAMI	
15	5990 N. Arlington Blvd. San Pablo, CA 94806	
16	Registered Nurse License No. 550052	
17	Respondent.	
18		
19	Complainant alleges:	
20	<u>PARTIES</u>	
21	1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this First Amended Accusation	
22	solely in her official capacity as the Executive Officer of the Board of Registered Nursing,	
23	Department of Consumer Affairs.	
24	2. On or about November 23, 1998, the Board of Registered Nursing issued Registered	
25	Nurse License Number 550052 to Sousan Ehteshami Khosravi, aka Sousan Sousan Ehteshami	
26	Khosravi, aka Mahnaz Ehteshami ("Respondent"). The Registered Nurse License was in full	
27	force and effect at all times relevant to the charges brought herein and will expire on February 28	
28	2014, unless renewed.	
	!	

///

JURISDICTION

- 3. This First Amended Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.
- 4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 5. Section 118, subdivision (b), of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

RELEVANT STATUTES AND REGULATIONS

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- "(a) Unprofessional conduct, which includes, but is not limited to, the following:
- "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

28 |

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

- "(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
- "(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
- "(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
- "(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.
- "(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.
- "(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

///

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

STATEMENT OF FACTS

Patient LM's Infiltrated Intravenous Site

- 11. At all relevant times, Respondent was employed as a registered nurse at Doctor's Medical Center ("DMC") in San Pablo, California.
- 12. On or about April 5, 2009, Respondent assumed care of Patient LM ("LM"), a 72 year-old male who had been admitted to DMC with complaints of nausea and vomiting. He was found to be anemic and in renal failure.
- 13. At approximately 8:00 a.m., Respondent noted that LM's right forearm intravenous ("IV") site was infiltrated and red, with a red line in the center.
- 14. Respondent did not inform LM's physician of the infiltrated IV site. Instead, a warm towel wrapped in an absorbent plastic pad was placed over LM's forearm.
- 15. Approximately five to ten minutes later, LM reported pain in his right forearm. Respondent removed the towel and observed that a blister (second degree burn) had formed. Respondent then wrapped LM's wound with a Kerlix (dry gauze) dressing.
- 16. Respondent failed to contact LM's physician regarding the blister that had formed on his right forearm. Respondent did not document the care that she provided to LM as a result of the infiltrated IV. There was no documentation that Respondent re-evaluated LM's second degree burn injury on her shift on April 5, 2009.
- 17. LM was diagnosed with cellulitis (skin infection) at the infiltrated IV site and placed on antibiotic therapy.

Patient LM's Gastrointestinal Procedure

- 18. On April 4, 2009, LM's physician wrote an order that he was to be kept NPO (nothing by mouth) after midnight, in preparation for a gastrointestinal procedure on the morning of April 5, 2009. At 8:00 a.m., while under Respondent's care, LM consumed half of his breakfast.
- 19. After LM left the floor for the procedure, Respondent at approximately 10:00 a.m., notified the GI lab that LM had eaten breakfast. By this time, LM had already been sedated for the procedure. The procedure was then aborted, with it being re-scheduled for the following day.

Patient DC's Cardiac Pause

- 20. On or about February 20, 2011, Respondent was assigned to Patient DC ("DC"), an 80 year-old female with a history of multiple cardiac problems, who was placed on continuous cardiac monitoring.
- 21. Towards the end of Respondent's shift, DC had a cardiac pause that lasted for 4.03 seconds. Respondent was alerted to this event and asked to check the patient. Respondent did not perform an evaluation of DC after this cardiac pause and failed to contact the patient's physician.

Unsafe Administration of Medications

22. On or about January 28, 2011, Respondent was observed administering medications to three (3) of her assigned patients. In each instance, Respondent failed to follow DMC's policy in that she administered medications without first confirming the patient's identity (checking the patient's name and medical record number on their ID band against the Medication Administration Order and/or Physician's Order, and asking the patient to state their name).

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence - Failure to Notify LM's Physician Regarding

Infiltrated IV and Condition)

23. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence and/or incompetence in that she failed to notify LM's physician that his IV had infiltrated and/or the attendant symptoms of skin redness at the site. The facts in support of this

cause for discipline are set forth above in paragraphs 12 through 15.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence - Treatment Without Physician Order)

24. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence and/or incompetence in that she treated LM's infiltrated/infected IV site without a physician's order, with said treatment leading to LM's development of a second degree burn on his right forearm. The facts in support of this cause for discipline are set forth above in paragraphs 13 through 15.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence - Inappropriate Treatment of Infiltrated IV)

25. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence and/or incompetence in that she treated LM's infiltrated/infected IV site by placing a warm towel wrapped in an absorbent plastic pad over his forearm leading to LM's development of a second degree burn on his right forearm. The facts in support of this cause for discipline are set forth above in paragraphs 13 through 15.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence - Failure to Notify Physician of Second Degree Burn Injury)

26. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence and/or incompetence in that she failed to notify LM's physician that he developed a second degree burn as a result of her treatment with a warm towel wrapped in an absorbent plastic pad. The facts in support of this cause for discipline are set forth above in paragraphs 15 and 16.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence - Treatment Without Physician Order)

27. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence and/or incompetence in that without a physician's order she treated LM's second degree burn by wrapping it in a Kerlix dressing. The facts in support of this cause for discipline are set forth above in paragraphs 15 and 16.

TENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence - Failure to Follow Physician's Pre-Operative Orders)

32. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence and/or incompetence in that she failed to follow the pre-operative orders of LM's physician that required he be kept NPO after midnight for the gastrointestinal procedure scheduled on the morning of April 5, 2009. The facts in support of this cause for discipline are set forth above in paragraph 18.

ELEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence - Failure to Promptly Advise GI Lab)

33. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence and/or incompetence in that she delayed in notifying the GI lab at DMC that LM had eaten half of his breakfast. The facts in support of this cause for discipline are set forth above in paragraph 19.

TWELFTH CAUSE FOR DISCIPLINE

(Incompetence - Failure to Assess DC's Cardiac Pause)

34. Respondent is subject to disciplinary action under Code section 2761(a)(1) for incompetence in that she failed to immediately assess DC after her cardiac pause and failed to notify DC's physician of this cardiac event. The facts in support of this cause for discipline are set forth above in paragraphs 20 and 21.

THIRTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence - Unsafe Medication Administration)

35. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence in that she repeatedly failed to properly identify patients prior to administering ordered medications. The facts in support of this cause for discipline are set forth above in paragraph 22.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 550052, issued to Sousan

1	Ehteshami Khosravi, aka Sousan Sousan Ehteshami Khosravi, aka Mahnaz Ehteshami;	
2	2. Ordering Sousan Ehteshami Khosravi, aka Sousan Sousan Ehteshami Khosravi, aka	
3	Mahnaz Ehteshami, to pay the Board of Registered Nursing the reasonable costs of the	
4	investigation and enforcement of this case, pursuant to Business and Professions Code section	
5	125.3;	
6	3. Taking such other and further action as deemed necessary and proper.	
7	DATED: April 23 2013 Foreign L. Laile	
8	LOUISE R. BAILEY, M.ED., RN Executive Officer	
9	Board of Registered Nursing Department of Consumer Affairs	
10	State of California Complainant	
11		
12	SF2012402267 40619855.docx	
13		
14		
15		
16 17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		